



Tackling Girls and Young Women's Reproductive Health through a Reproductive Justice Framework

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Tackling Girls and Young Women's Reproductive Health through a Reproductive Justice Framework

Preliminary Report

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March 2018

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Project partners visiting the Likhaan Center For Women's Health, Quezon City, the Phillipines, November 2017.

INTRODUCTION

Project Background

Funded by a Global Challenges Research Fund (GCRF) pump priming grant from the Department for the Economy (Northern Ireland) this project set out to develop an expert team utilizing the multi-disciplinary framework of Reproductive Justice to address the complex issue of reproductive health. Team members' disciplines include social policy, law, politics, public health, sustainable development, medicine, and psychology.

The aims of this project were:

- To identify intersecting factors hindering access to reproductive health in case study areas.
- To build an international network that would aid in the development of a large-scale project.
- The production of theoretical and policy knowledge to inform a large-scale grant application and academic outputs.
- To develop a large-scale grant application focusing on improving the reproductive health of women and girls. Programmes will be designed from a bottom up approach in tandem with those directly affected.

Project Partners

Team Member	Discipline	Geographic area of expertise
Sylvia Estrada Claudio (University of the Philippines)	Medicine, psychology, activism	Philippines
Junice Demeterio Melgar (Likhaan Center For Women's Health)	Primary health care, maternal mortality, contraception and unsafe abortion	Philippines
Catriona Macleod (Rhodes University)	Psychology (teenage pregnancy, abortion, sexuality education, reproductive justice)	South Africa
Malvern Tatenda Chiweshe (Rhodes University, London School of Economics)	Psychology (Family planning, abortion, adolescents reproductive justice)	South Africa/ Zimbabwe
Marisa Viana (RESURJ)	sustainable development, public health (HIV, reproductive health), transnational programs, adolescents and young people	Brazil/ South America/ Global
Claire Pierson (University of Liverpool)	Politics, Law (global gender security)	UK/ Northern Ireland/ Ireland
Fiona Bloomer (Ulster University)	Social policy (reproductive health, abortion)	UK/ Northern Ireland/ Ireland

The project partners were responsible for design of the preliminary project, advising on briefing papers, participating in a partnership workshop and design of the large scale project. The research team for the project comprised Claire Pierson, Fiona Bloomer and Noirin MacNamara. The research team were responsible for gathering primary research, conducting desk research, overall project management and liaison between the project partners. The research team were also responsible for project outputs including briefing papers, reports to the funder and academic outputs. Colleagues Mina Tenorio (Likhaan), Ciara Fitzpatrick (Ulster), and Deborah Coey (Ulster) provided administrative support to the project.

Strategic Priorities

This project addresses a range of strategic priorities:

- GCRF Priority: Equitable Access to Sustainable Development (Theme: sustainable health and well-being).
- UN Sustainable Development Goals: Goal 3 health and well-being; Goal 5 Achieve gender equality and empower all women and girls.
- Priority areas for the UK Aid strategy (DFID): maternal health and family planning.

The World Health Organisation, UN Population Fund and the Gates Foundation advocate good reproductive health (including maternal health, sexual health, family planning) as key to sustainable development. Over 300,000 individuals die annually from causes related to pregnancy, childbirth and unsafe abortion, with thousands more encountering complications. Girls and young women are disproportionately affected. Under-developed health infrastructures, limited access to health information, and unmet family planning needs hinder improvement to reproductive health¹.

The project focused on two countries, South Africa and the Philippines. The countries have been chosen as they both exhibit challenges in improving reproductive health, including structural but also societal barriers such as stigmatization, conservative and religious attitudes to reproductive health. In addition, both have contrasting legal positions on abortion (South Africa liberal, the Philippines restrictive).

¹ The terms 'woman' and 'women' are used in this report in order to be consistent with existing literature. In using these terms we mean to include trans men, non binary people and anyone who can get pregnant.

PROJECT OUTPUTS

Desk Research

Three briefing papers have been produced by the research team:

1. Theoretical Frameworks
2. International Policy overview
3. Case study overview

Key findings from the briefing papers are summarised in the following sections. The briefing papers provided the foundation for discussions with the partners and will inform academic outputs associated with the preliminary project.

Workshop

Project partners attended a 3-day workshop in the Philippines in November 2017. This allowed for the team to meet as a whole and to map the context and barriers to reproductive health in each setting. Key findings from the workshops are summarised in the following sections. The project team also undertook a site visit to the Likhaan Center For Women's Health and met with staff delivering reproductive health services at the centre.

Develop an international multidisciplinary network

Preliminary meetings via skype allowed for the project partners to meet the research team. Further consideration of networking opportunities formed a key part of the workshop, with detailed plans made on developing a large-scale project.

Grant Proposal

Project partners developed a large-scale grant proposal informed by the briefing papers and the issues identified at the workshop.

Generate new knowledge

The research team are developing academic outputs informed by new knowledge generated by the project on the case study regions.

In this section of the report we summarise key evidence related to reproductive health globally and provide an overview of reproductive health data in each case study area. This is followed by a consideration of reproductive justice and the theoretical approach for the large-scale study.

Reproductive Health Globally

Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth. The overwhelming majority of maternal deaths occur in the global south (WHO, 2017). Maternal mortality is higher in women living in rural areas, among poorer communities and for young adolescents. Under-developed health infrastructures, inequality in access to healthcare, health services that do not prioritise reproductive health, limited access to health information, and unmet family planning needs, all hinder improvements to reproductive health (Bloomer et al, forthcoming; Kassebaum et al., 2014; Sedgh et al., 2016).

Underlying these structural factors are conservative social and cultural discourses that stigmatise reproductive healthcare and limit women's ability to control their reproductive life (Blofield, 2008; Bloomer et al, forthcoming; Durham, 2005; Hulme, 2009).

Reproductive Health the Philippines

The Philippines has a population of approximately 102.25 million, with just under 13 million living in the capital city Manila (UN Data, 2017). In the Philippines access to healthcare is unevenly distributed according to wealth and location, with poorer, less educated and those living in rural areas particularly affected. Abortion is prohibited, although no one has yet been imprisoned under the highly restrictive law, the legal framework contributes to a context that stigmatizes abortion and results in high numbers of unsafe abortion (Likhaan and Arrow, 2016: 17).

Unintended pregnancy and maternal health

Whilst data on unintended pregnancies is not readily available, a study using data from 2008 estimated that 54% of all pregnancies in the Philippines were unintended. It was also estimated that 90% of unintended pregnancies occurred among women who were either using traditional contraception or no contraception (Darroch et al., 2009).

Traditional or natural family planning methods included calendar (periodic abstinence) and withdrawal methods. In 5 surveys (DHS 1993-2013), on reasons for not intending to use contraception, “religious prohibition” was cited by 3-6% of women; “wants more children” by 10-21%; “health concerns” by 10-26%; and “fear of side effects” by 14-22%. Most non-users or traditional method users do so mainly because of health/side effect concerns and not because of religious beliefs.

Unmet need for contraception is estimated at 17.5%; however, in younger age groups (15-19 and 20-24) unmet need ranges from 22-30%. Unmet need is notably higher amongst those in lower income groups ([Philippines National and Demographic Health Survey](#), 2013). The Guttmacher Institute report that if the unmet need for contraception was addressed in the Philippines, using a modern method, then ‘unplanned births would decline by 800,000 per year and there would be 500,000 fewer abortions per year’ (Guttmacher, 2013).

The country’s maternal mortality ratio (MMR) failed to improve in the last 20 years. It was measured at 209 in 1990, and 221 in 2011. The target for 2015 was 52 (NEDA & UNDPD, 2014). According to the WHO, of 95 countries with MMRs over 100 in 1990, 26 have made no progress. The Philippines is one of the 26 (WHO, 2015d). In a study of the death certificates of women who died from obstetric conditions (2010-2014), the top-5 causes were eclampsia (20%), complications of labour and delivery (17%), post-partum haemorrhage (16%), pre-eclampsia (13%), and abortion (10%) (De Guzman et al., 2016). The authors noted that death certificate coverage in the Philippines is low (65% in 2009). Given the complete prohibition and stigma that surrounds abortions in the country, it is likely that abortion deaths are underreported more than the other causes of maternal deaths.

Abortion

Approximately 1,000 women die annually from abortion complications in the Philippines. Two studies from hospital reports estimate that 100,000 women were hospitalized due to induced abortion complications in 2012 while many others suffered complications that went untreated. It is estimated that there were 560,000 abortions in 2008 and 610,000 in 2012 (Guttmacher, 2013)².

Data collection issues

With regard to data collection generally, and on maternal mortality in particular in the Philippines, Mujer Quintos notes that maternal mortality figures based on death certificates in the civil registry is likely underreported and thus the data needs to be approached with caution. This is especially pertinent in areas of conflict such as the Autonomous Region of Muslim Mindanao (ARMM) (Mujer Quintos, 2017: 3). Other reasons for under-reporting include neglect and the inadequate training of health workers which may result in incorrect or inaccurate classifications by health workers (ibid: 3).

In contrast the maternal mortality ratio (MMR) of 221 in 2011 is likely not underreported. It is probably on the high side because the methodology (indirect sisterhood method) asks about deaths while pregnant, which may inadvertently include non-maternal deaths (e.g. deaths from accidents while pregnant).

Policy and Law

The Responsible Parenthood and Reproductive Health Act of 2012 has the potential in the Philippines to significantly improve women's health and wellbeing and reduce maternal mortality. The Act seeks to provide:

² Two studies have been conducted, based on nationwide collection of hospital reports. Projections were done only for a minority of hospitals where abortion complications were not in the top-10 causes of hospitalization; and to separate induced from spontaneous abortions. The methodology is called Abortion Incidence Complications Method (AICM). See Singh et al., Chapter 6 <https://www.guttmacher.org/pubs/compilations/IUSSP/abortion-methodologies.pdf>

- Access to reproductive health and family planning services with due provision of the informed choice of service users.
- Maternal healthcare services.
- Youth education on reproductive health and sexuality.
- Humane, nonjudgmental and compassionate treatment of women needing post-abortion care.

In recognition of the high levels of unsafe abortion, and in response to lobbying from health professionals and advocacy groups, the Philippines government introduced a policy in 2000 to improve post abortion care (Luczon and Francisco, 2015). The policy, Prevention and Management of Abortion Complications (PMAC) was later updated in 2016. Whilst the policy did not address the highly restricted legal context it was a significant development in demonstrating that the government recognised that the high levels of unsafe abortion needed to be addressed.

The implementation of the PMAC policy and the Responsible Parenthood and Reproductive Health Act of 2012 have however both been hampered by under-funding, lack of knowledge amongst providers and the reluctance of providers to implement changes (Gipson et al, 2011; Masilungan, 2011; Padilla and Visbal, 2017). The 2016 policy became controversial among some professional health associations, and this was exploited by conservative groups to block the appointment of a Secretary of Health (Terrazola & Kabiling, 2017). As a result, the 2016 policy was replaced by a more conservative policy now called “National Policy on the Prevention of Illegal and Unsafe Abortion and Management of Post-Abortion Complications” (Department of Health, 2018). PMAC 2016 was explicitly revoked by the 2018 AO. Now there is an explicit list of PAC procedures at basic level maternity facilities (birthing homes, BEMONCs), which excludes MVAs or the removal of retained products of pregnancy (implied restriction to CEMONC facilities only, meaning hospitals with operative/surgical capacity).

Public Opinion

In overall terms, surveys of public attitudes to abortion in the Philippines indicate it is an issue that is morally unacceptable to most respondents, with a smaller number believing that contraception is also unacceptable:

Table 1 Views on abortion and contraception in the Philippines

Question	Morally acceptable	Morally unacceptable	Not a moral issue	Depends on situation (volunteered)	DK/ Refused	Total
Do you personally believe that ... Having an abortion is morally acceptable, morally unacceptable, or is it not a moral issue?	2	93	4	0	0	99
Do you personally believe that ... Using contraceptives is morally acceptable, morally unacceptable, or is it not a moral issue?	60	29	9	1	1	100

Source: Pew Research Global Attitudes Survey 2014 (% rounded up or down)

However, when survey questions are not about general moral acceptability, more people agree with changing the status quo on abortion. A 2014 survey of 1,000 adult Catholics had 25% of respondents agreeing that abortion should be allowed in some cases, with a further 2% saying yes to all cases (Univision, 2014). A 2004 survey of 4,163 women aged 15-49 resulted in 60% saying that the abortion law should allow a woman to end an unwanted pregnancy to save her from dying; 32% if it was to protect her health; 21% if the pregnancy is from incest, and 18% if from rape (Cabigon, Singh, & Juarez, 2006). A 1991 survey of 1,200 adult men and women resulted in 33% saying that the law should probably or definitely allow a legal abortion if there is a strong chance of serious defect in the baby; 20% if the family has a very low income and cannot afford any more children (International Social Survey Programme, 1991).

Despite majority public opposition to abortion, a 2011 qualitative study on the attitudes of young, urban, mostly lower income adults revealed a more nuanced picture, depending on the circumstances (Gipson et al, 2011). Participants stated that the amount of involvement and support of the male partner and parents was integral for decision making re abortion for unmarried non-cohabiting couples. For married or cohabiting partners, the most frequently cited factors impacting on decision making

were short birth intervals and the inability to provide food and medical care for children.

Gipson et al, (2011) found that participants of focus groups were more likely than those from individual in depth interviews to speak disparagingly of women who had abortions and of family members who were supportive of abortion. Pregnancy was viewed as punishment for unmarried women for being a 'wanderer' or a 'tramp'. Women who had had an abortion were referred to as 'careless and "loose," or as drug users or sex workers' (Gipson et al, 2011: 266). In spite of this participants were more supportive of pregnancy in some circumstances such as threats to the woman's health, partner abandonment and economic concerns (ibid: 269). Indeed, the data collected in the interviews revealed the complexity of this issue for young adults (ibid: 270).

In sum, in considering the data on reproductive health in the Philippines it is clear that the prohibitive legislative framework results in high levels of unsafe abortion. High levels of maternal mortality are also evident. The situation is impacted by unmet need for contraception, poor health infrastructure, inadequate services and negative views about abortion and contraception amongst health professionals and the public. Initiatives to improve reproductive health and unsafe abortion have been hampered by underfunding.

Reproductive Health South Africa

South Africa has a population of approximately 55 million, with just over 2 million living in the capital city Pretoria (UN Data, 2017). Access to healthcare for all is enshrined in the South African Constitution but significant inequities are evident. These inequities are rooted in the legacy of racialized and segregated healthcare during Apartheid. These include differences in funding between the private and public sectors, high travel costs particularly in rural areas, high out of pocket payments for care and lengthy waiting lists. Poor, uninsured black Africans and those living in rural areas are all more likely to experience inequitable access to healthcare services and poor health outcomes as a result (Harris et al., 2011; Jewkes et al., 2005).

Unintended pregnancy and maternal health

It is estimated that there are 636,040 unintended pregnancies annually in South Africa (Le et al., 2015). Contraceptive use has increased in uptake in recent years, with unmet need estimated at 14.7%; however, in younger age groups (15-19 and 20-24) unmet need is close to 30% (Department of Health, 2017). The Department of Health encourages dual contraception to deal with risk of pregnancy and of contracting HIV, which in the late 20th century became a significant health problem in South Africa. New HIV infections have decreased by 49% since 2010, though South Africa has 19% of the global number of people living with HIV (UNAIDS, 2016). Incidences of HIV remain a major factor in all sexual and reproductive health matters.

Maternal mortality ratios are estimated at 141 deaths per 100 000 live births, again whilst this has decreased in recent years it remains at a high level (UN Maternal Mortality Estimation Group, 2014).

Abortion

Over half of abortions in South Africa are unsafe despite a liberal abortion law (Sedgh et al., 2011). Those at most risk include those in lower socio-economic groups, those living with HIV, those who are Black and those living in provinces of Gauteng, Limpopo or KwaZulu-Natal (Mosley et al., 2017:918). Multiple barriers to safe abortion have been identified; including abortion stigma, a lack of qualified staff and

resources, the absence of clear guidance from provincial health departments, a lack of knowledge about access to free abortions, migrant status, and a fear of discrimination or confidentiality breach by health workers. Inadequate resources, training and long waiting lists place a particular burden on abortion providers (Hodes, 2016; Lince-Deroche et al., 2015; Röhrs, 2017).

Policy and Law

The Choice on Termination of Pregnancy Act (CTOP) (Act No. 92 of 1996) (amended in 2008) replaced the Abortion and Sterilisation Act (1975) in South Africa, which was very restrictive (CTOP 1996; CTOP 2008). The CTOP is regarded as one of the most liberal legislative frameworks in the world. It allows for abortion on request up to the 12th week of the pregnancy, with restrictions added beyond 13 weeks including:

- (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- (iii) the pregnancy resulted from rape or incest; or
- (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman.

The Choice on Termination of Pregnancy Amendment Act 2008 sought to extend the number of facilities providing abortion services and to allow registered trained nurses to provide first-trimester abortions.

Although the legislation provides a liberal framework for abortion, the political will to implement it across health facilities is weak. In tandem, public discourse about abortion tends to be negative 'centring on morality, foetal rights and personhood, culture and the family' (Chiweshe et al, 2017: 206) and research indicates many women are unaware of their rights and entitlements with regard to abortion. The Sexual and Reproductive Justice Coalition (a coalition of organisations and individuals engaged in advocacy, research, service delivery, education, policy analysis and activism work in the fields of gender, sexual and reproductive justice, health, rights and care) are working to address these issues. Specifically, this includes developing guidelines on providing abortion services which are expected to be released in 2018.

Public Opinion

Public opinion surveys in South Africa indicate 31% of respondents believe that abortion is morally unacceptable, with a notable 19% stating it depends on the situation. The majority of respondents also believe contraceptive use is morally acceptable.

Table 2 Views on abortion and contraception in South Africa

Question	Morally acceptable	Morally unacceptable	Not a moral issue	Depends on situation (volunteered)	DK/ Refused	Total
Do you personally believe that ... Having an abortion is morally acceptable, morally unacceptable, or is it not a moral issue?	10	61	8	19	2	100
Do you personally believe that ... Using contraceptives is morally acceptable, morally unacceptable, or is it not a moral issue?	68	15	9	6	2	100

Source: Pew Research Global Attitudes Survey 2014 (% rounded up or down)

Research studies in rural areas have identified that whilst participants could identify benefits to improved access to abortion, that it was often constructed in a negative manner and associated with colonialist interventions. As a result, opposition to abortion was seen as defending the community's culture (Macleod et al., 2011). The loss of gendered and generational power relations were also evident in how abortion was constructed (ibid, 2011). In urban areas, amongst young people whilst a more liberal approach to abortion was identified, hostility was also evident, particularly amongst those who attended a Catholic school (Gresh and Maharaj, 2014).

In sum with regard to reproductive health in South Africa the evidence reveals high rates of maternal mortality and unsafe abortion. Despite a liberal legal framework access to safe abortion remains difficult. Factors affecting this include the absence of guidance and adequate training for providers, under-funded services, and abortion stigma.

Project Approach - Reproductive Justice

At the outset of the project the project partners had agreed that reproductive justice provided the best approach to considering the multiple issues impacting on reproductive health.

The reproductive justice approach emerged in the US in the late 1990s as a social movement following recognition that the reproductive injustices experienced by women of colour were not recognised by the state nor by the mainstream women's rights movement. Reproductive justice is defined by three key principles: the right to have a child; the right not to have a child; the right to parent children in safe and healthy environments (Ross and Solinger, 2017: 9). Led by the SisterSong organisation it was asserted that an approach that combined human rights and social justice was needed to address the multiple reproductive oppressions experienced by women of colour.

From this social movement emerged the Reproductive Justice Framework, primarily developed by women of colour academics and activists. It provided a historical analysis of reproductive injustices, alongside analysis of legal, policy and technological contexts from an intersectional and interdisciplinary approach (Bloomer et al, forthcoming; Silliman et al 2004). Core to the framework is the argument that to achieve reproductive justice entails access to material resources that enable: high quality health care, housing and education, a living wage, a healthy environment and a safety net for when these resources fail. Safe and dignified fertility management, childbirth and parenting are impossible without these resources (Ross and Solinger, 2017: 9).

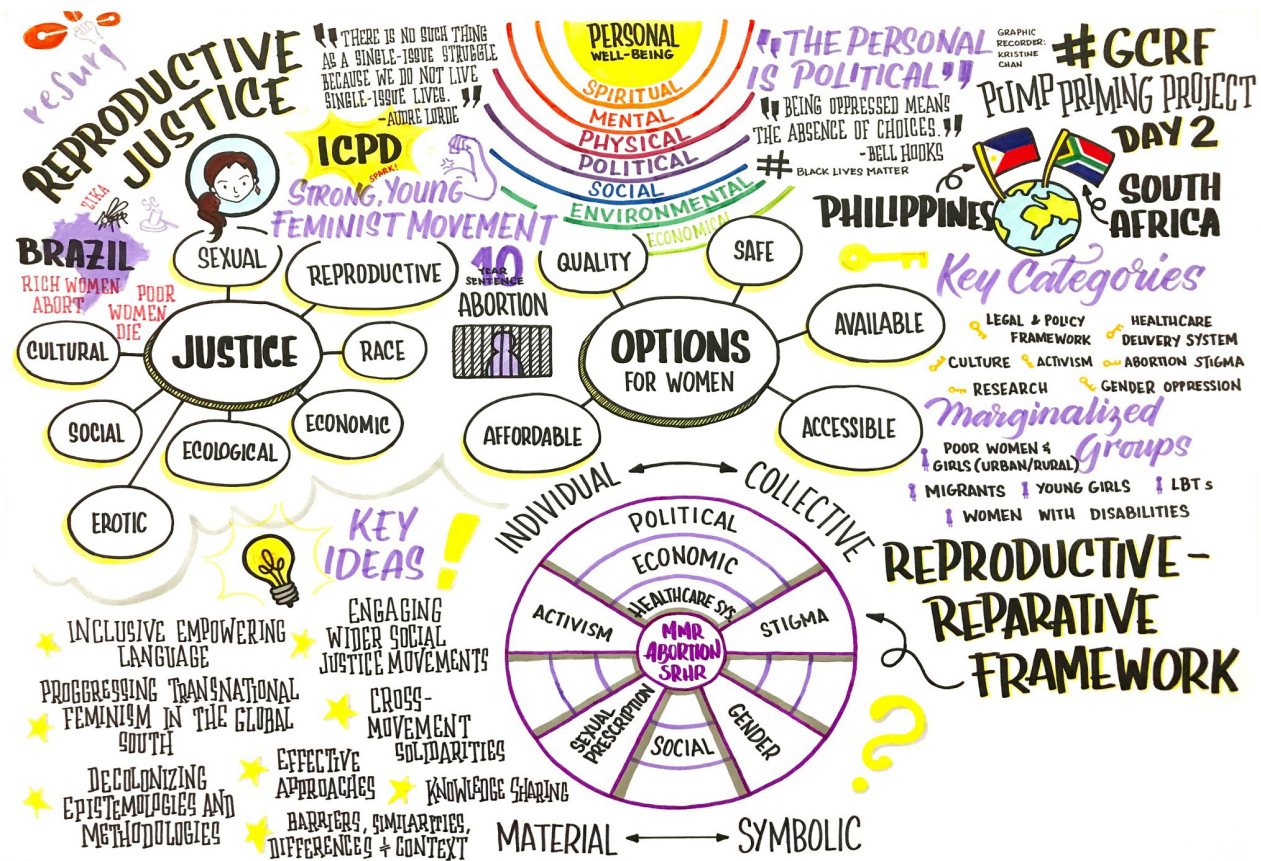
At the partner workshop in November 2017 a detailed consideration of the case study areas was informed by analysis of reproductive justice theoretical issues, summarised in figures 1 and 2:

Figure 1 Graphic Representation of review of case study areas and reproductive health issues



Graphical image created by Kristine 'Tin' Chan and Ryan 'Red' Tani (Filipino Freethinkers
<http://filipinofreethinkers.org/>)

Figure 2 Graphic Representation of theoretical considerations



Graphical image created by Kristine 'Tin' Chan and Ryan 'Red' Tani (Filipino Freethinkers
<http://filipinofreethinkers.org/>)


Theoretical approach

The project partners developed an innovative and critical framework, the reparative reproductive justice framework (Figure 3), to allow an exploration of cultural discourses and factors affecting access to reproductive health, with a particular focus on safe abortion. This approach will be implemented in the large-scale project which was designed at the workshop.

Figure 3: Reparative Reproductive Justice Framework



The framework is grounded in the reproductive justice approach which recognises that achieving good reproductive health is dependent upon a range of intersecting factors



(political, economic, health care systems, social) influenced by stigma, gender, sexual prescriptions and activism. In the reparative reproductive justice framework developed by Macleod et al (2016) these are structured around individual / collective and material / symbolic dimensions:

Individual material dimension	Collective material dimension
The facilitation of autonomous decision making with regard to the outcome of a pregnancy. Key requirements: Legislative enablement and supportive healthcare provision	The provision of legal state-sponsored healthcare resources that make abortion legal, accessible and safe for all women. Key requirements: Well-funded, widely available, legal healthcare resources
Individual symbolic dimension	Collective symbolic dimension
The understanding of individual lived experiences of unsupportable pregnancies. The understanding of abortion within the social and structural dynamics of local settings.	The ways in which public discourses about and social attitudes to abortion construct available subject positions for women seeking abortions

The future project, with its focus on cultural contexts and discourse, will focus on the symbolic level of analysis. The symbolic level may be described as that which gives legitimacy within a particular society to the act of abortion and therefore may translate up into the material level, which provides legal and practical access to abortion services.

The outcomes of such an analytical approach is based upon the notion of reparations and supportability. Reparative justice usually refers to the recompense offered to remedy an injustice. Macleod et al (2017) maintain that social and bodily injustices ‘require a range of forms of social repair, including transforming the unequal social conditions within which reproduction takes place and the provision of safe, accessible and supportive abortion’

(ibid: 603). They further posit that reparative justice does not start from the position of restoring a deficient status but rather seeks to affirm the equal dignity and rights of those who have been denied such rights. Reparative justice is a process that recognises those harmed 'as persons, with agency, to whom society has an obligation to make just repairs' (ibid: 603).

The implementation of the framework therefore must be context-dependant. In the Philippines, it will consider factors restricting legislative change and in South Africa, it will consider factors that continue to impede women accessing safe and legal abortion under the more liberal legislative regime.



Project partners meeting staff at the Likhaan Center For Women's Health, Quezon City, the Phillipines, November 2017.

CONCLUSION



Partner workshop, University of the Philippines, November 2017

At the concluding stages of this preliminary period of the project, the project partners identified that there was a clear need for a large-scale project that would seek to:

- (1) document social and cultural factors impeding access to quality reproductive health and rights for women and girls in two countries in the global South, the Philippines and South Africa, with a focus on access to safe abortion; and
- (2) produce knowledge to inform reproductive health policy and practice and future debates about legal changes.

The project partners have designed a project to meet these needs and are currently seeking funding for this.



Partner workshop, University of the Philippines, November 2017

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